



Phone: 1-877-537-0722
FAX TO: 1-877-537-0720

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

APPEAL/ RECONSIDERATION
PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid: _____

DOB: _____ City: _____
Month/ Day/ 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____ NPI #: _____

Medicaid ID #: _____ Phone #: _____ FAX: _____

City: _____ State: _____

Physician's signature and date

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider #: _____

Drug Name: _____ Strength: _____

Reference PA #: _____

City: _____ State: _____ Phone #: _____ FAX: _____

REQUEST INFORMATION

Date of Request: _____ Requested By: Physician Beneficiary

Date of Denial Notification: _____

*Requester is encouraged to submit any additional information to support the request for appeal

RATIONALE/ MEDICAL REASON FOR DISAGREEMENT

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